

**CAREFIRST - DC EXCHANGE 5T  
Namenda (HMF)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Namenda (HMF).

**Patient Information**

**Patient Name:**   
**Patient Phone:**  -  -   
**Patient ID:**   
**Patient Group:**   
**Patient DOB:**  /  /

**Physician Information**

**Physician Name:**   
**Physician Phone:**  -  -   
**Physician Fax:**  -  -   
**Physician Addr.:**   
**City, St, Zip:**

**Drug Name (select from list of drugs shown)**

Namenda XR Titration Pak (memantine SR)    Memantine

**Quantity:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Strength:** \_\_\_\_\_  
**Route of Administration:** \_\_\_\_\_ **Expected Length of Therapy:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_  
**Comments:** \_\_\_\_\_

**Please check the appropriate answer for each applicable question.**

- 1. Does the patient have any of the following diagnoses: A) moderate to severe dementia of the Alzheimer's type, B) vascular dementia?    **Y**     **N**
- 2. Is this request for continuation of therapy?    **Y**     **N**
- 3. Does the medication continue to provide benefit to the patient?    **Y**     **N**
- 4. Is the diagnosis supported by a validated cognitive assessment within the past 12 months?    **Y**     **N**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

**Prescriber (Or Authorized) Signature and Date**

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